Oregon Health Insurance Marketplace

Recommendations for the Creation of a Premium Assistance Program for Low-income Compact of Free Association (COFA) Islanders

November 9, 2016

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Recommendations

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I. Executive Summary

A high-level overview of the report.

The Oregon Department of Consumer and Business Services (DCBS) developed this report for the Legislative Assembly and the interim committees of the Legislative Assembly related to health in accordance with House Bill 2522. Enacted in 2015, HB 2522 requires DCBS to develop recommendations for the creation of a premium assistance program for low-income Compact of Free Association (COFA) islanders to enable them to purchase health benefit plans through Oregon's health insurance marketplace and to pay the out-of-pocket expenses incurred under the plans.

This report provides background information, describes the process DCBS used to develop its recommendations, and provides explanations of its recommendations.

Summary of DCBS's Recommendations

If the Legislative Assembly chooses to enact legislation implementing a COFA premium assistance program, DCBS recommends the following:

i. DCBS should develop the specific requirements of the program through the rulemaking process to allow flexibility.
ii. In general, program eligibility requirements should align with other related federal and state program requirements, including requirements of HealthCare.gov.
iii. If enough funding is made available, the premium assistance program should cover the individual's share of premium and in-network out-of-pocket costs to create coverage roughly equivalent to Medicaid. By limiting plan selection to cost-share reduction variants of silver-level plans, the state can maximize federal subsidies, limit out-of-pocket expenses for the state, and provide participants with benefits more generous than a platinum plan.
iv. DCBS should pay insurance companies directly for participants' premiums and should look for ways to streamline the payment of in-network out-of-pocket costs to avoid administrative burden for the state and barriers for participants. When determining program specifics, such as plan selection, DCBS will need to find a way to balance the interests of the state, insurers, and program participants.
v. The premium assistance program should leverage federal subsidies for participants. Additional state funding should be allocated to provide assistance to pay for the individual's share of premiums and in-network out-of-pocket costs and to provide additional resources to DCBS to enable it to administer the program.
vi. DCBS will need at least six months to develop the program. Initial enrollment should coincide with the 2017 plan year open enrollment period (fall 2016).
vii. DCBS should coordinate the development of this program with other affordability efforts underway; however, the proposed program will most likely help COFA islanders access affordable, high-quality health insurance sooner than other efforts.

Estimated Costs of the Program

Based on the above recommendations, the State of Oregon could access considerable federal subsidies by implementing the proposed program. The federal contribution toward premiums alone would be about $9 for every $1 the state contributes toward premiums. The total federal contribution in tax credits for 1,500 participants could total up to more than $4,220,000 per year. The federal government would contribute additional funds through cost-share reductions for participants.

DCBS estimates that the maximum total cost of the program for the state would be between approximately $1,039,000 and $1,823,000 per year. This includes between $818,000 to $1,602,000 per year for assistance and approximately $221,000 per year for administration.

Please note that all of DCBS's projections in this report are maximum ranges to provide an estimate of the most the proposed program could cost. The actual cost could be less than the estimates provided. For example, fewer people may participate in the program during its early stages, while others may not use their insurance; however, DCBS proposes to develop a comprehensive outreach and education campaign in partnership with stakeholders that will help maximize participation from the start and ensure that participants make the most of their insurance.

DCBS does not have enough data about certain factors, such as household size and the health status of possible participants, to create more accurate projections for this report. This would be a new, and in many ways unique, program, and DCBS would not have more accurate information about certain factors until the program is implemented. Also, the differences between actual and projected maximum costs may be marginal since the total potential population is not that large to begin with, limiting the range of possibilities.

Accordingly, the estimates in this report assume: 1) an estimated population of 1,000 to 1,500 eligible COFA islanders in Oregon; 2) all eligible individuals will participate in the program from the start and continue for 12 months; 3) all participants live in one-person households; and 4) all participants will reach their annual out-of-pocket maximums. DCBS also based its estimates on existing, 2016 plan year rates since rates for 2017 have yet to be determined. 2017 plan year rates could potentially be higher than 2016 plan year rates. However, this would have a small effect on the estimates for state liability because Oregon would assume responsibility only for the member share of premium – determined as a percentage of household income - and cost-sharing, with the federal government assuming responsibility for the balance of premium and cost-sharing.

II. Background

Background on COFA and HB 2522.

COFA is a unique relationship between the United States and the independent nations of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia. The compact allows Palauan, Marshallese, and Micronesian citizens (also collectively known as

COFA islanders or citizens of the Freely Associated States (FAS)) to enter the United States without work permits or visas to study, live, and work; join the United States military; and access benefits available to United States citizens, such as driver's licenses and health care.

The economies of the COFA islands are heavily intertwined with that of the United States, and many COFA islanders have moved to the United States for education and work opportunities. Many islanders have medical conditions that resulted from exposure to nuclear testing conducted by the United States military in the islands.

The State of Oregon has developed comprehensive health reform plans with the goals of better health, better care, and lower costs for Oregonians. Like all other Oregonians, COFA islanders living in Oregon need access to affordable, high-quality health care. COFA adults are not eligible for Medicaid (known as the Oregon Health Plan (OHP) in Oregon) as a result of the Federal Personal Responsibility and Work Opportunities Act of 1996. COFA islanders are eligible for qualified health plans and financial assistance provided through the health insurance marketplaces created by the Patient Protection and Affordable Care Act of 2010 (ACA). However, advocates and stakeholders believe the cost of health insurance, even after federal subsidies, is often too high for many low-income islanders to afford.

In 2015, the State of Oregon enacted HB 2522 to help ensure that COFA islanders living in Oregon are "fairly treated in recognition of the special and unique relationship between the COFA islands and the United States and of the need for the United States to maintain a strong military and economic presence in the COFA islands." HB 2522 requires DCBS to "develop recommendations for the creation of a premium assistance program for low-income COFA islanders to enable them to purchase health benefit plans through the health insurance exchange and to pay the out-of-pocket expenses incurred under the plans." Premium assistance includes, "the payment or reimbursement of premium costs for a qualified health plan and the out-of-pocket costs associated with receiving services covered by the plan."

Under HB 2522, DCBS's recommendations may include but are not limited to:

(a) Eligibility requirements;
(b) The amount of assistance;
(c) How the assistance should be distributed among eligible individuals; and
(d) The cost and financing of the program, including whether federal funds or other funds may be available.

HB 2522 requires DCBS to "convene an advisory group that includes COFA islanders from each of the affected communities and other stakeholders to assist and advise the department in developing the recommendations."

DCBS must report its recommendations to the Legislative Assembly and to the interim committees of the Legislative Assembly related to health by September 15, 2016.

III. DCBS's Recommendation Development Process

A description of the process used to develop the recommendations, including the development and processes of the advisory group.

When DCBS learned about HB 2522, the agency began meeting with advocacy groups and members of the community to learn more about the issues and to begin identifying key stakeholder groups. On August 3, 2015, DCBS convened a stakeholder meeting that included representatives from the COFA islands, advocacy groups, insurers, and the Oregon Health Authority (OHA). During that meeting, stakeholders and DCBS discussed the development of the advisory group. Based on the stakeholders' recommendations, DCBS sent invitations to 18 individuals and organizations for the advisory group, representing all of the groups mentioned above. The following individuals agreed to serve on the advisory group:

Name	Title	Organization
David Anitok	President Board Member	Oregon Marshallese Community COFA Alliance National Network (CANN)
Kianna Angelo	Founder & Executive Director Board Member	Living Islands COFA Alliance National Network (CANN)
Theresa Barney	Manager of Operations & Health Care Reform, Sales & Account Services	Moda Health
Sandra Clark	Health Equity Project Manager	Health Share of Oregon
Joe Enlet	President	COFA Alliance National Network (CANN)
Regan Gray	Government Relations	Okulitch and Associates
Loyd Henion	Board Member	COFA Alliance National Network (CANN)
Faith Kebekol	Member	Palauan community in the Willamette Valley
Teresa Lavagnino	Coordinator, Health Programs	Immigrant and Refugee Community Organization (IRCO)
Bennie Moses-Mesubed	Board Member	COFA Alliance National Network (CANN)
Kristina Narayan	Policy Associate	Asian Pacific American Network of Oregon
Paulina Perman	Member Board Member Treasurer	Micronesian Islander Community (MIC) Living Islands COFA Alliance National Network (CANN)

Joseph Santos-Lyons	Executive Director	Asian Pacific American Network of Oregon
Cathie Skreen	Director of Membership Administration	Kaiser Permanente
Emily Wang, MPH	Health Equity Policy Analyst	OHA Office of Equity and Inclusion

DCBS met with its advisory group on September 10, 2015, October 15, 2015, and November 3, 2015. All meetings were open to the public, advertised on OregonHealthCare.gov, and attended by legislators and stakeholders, in addition to those on the formal advisory group. At the meetings, discussions included, but were not limited to, the following topics: background on COFA and HB 2522, report and recommendation development processes and timelines, working with HealthCare.gov, program eligibility criteria, the cost for the state to cover premiums and in-network out-of-pocket costs, potential plan design options, program administration processes and costs, program outreach needs, and program implementation timelines. Discussions were open to all who attended, not just advisory group members.

In addition to working with the advisory group, DCBS conducted considerable research into other premium assistance programs, including other assistance programs for COFA islanders. DCBS also discussed the potential program with the Centers for Medicare and Medicaid Services (CMS) to determine its feasibility within the ACA and with using the federal technology, HealthCare.gov, for individual eligibility and enrollment.

DCBS developed this report based on the input provided by the advisory group and information it gathered from its research efforts. DCBS discussed all potential recommendations with the advisory group and gave the advisory group the opportunity to review and provide feedback on the contents and conclusions of this report. DCBS finalized its recommendations based on that feedback.

IV. DCBS's Recommendations

In-depth description of DCBS's recommendations.

i. Development of program requirements

Recommendation: DCBS should develop the specific requirements of the program through the rulemaking process to allow flexibility.

The creation of a premium assistance program requires statutory authority in order to provide DCBS with the funding and authority to administer the program. If the Legislative Assembly chooses to enact legislation implementing a COFA premium assistance program, DCBS recommends that the agency be given authority to develop the specific requirements of the program through rulemaking. While other organizations and states run similar premium assistance programs, the proposed program would be unique in certain respects, some of which are described below.

One challenge is that Oregon uses the federal portal, HealthCare.gov, for individual health insurance eligibility and enrollment. If Oregon managed its own eligibility and enrollment website, the state could possibly make changes to the website to help automate and streamline program processes. Unfortunately, the federal government indicated to DCBS that such changes could not be made to HealthCare.gov. Without the option of automation, DCBS would need to develop mostly manual processes to administer the program.

Another potential challenge is that, unlike other premium assistance programs, HB 2522 contemplates a program where the state pays for in-network out-of-pocket costs in addition to premiums. Out-of-pocket costs are the expenses for medical care that are not reimbursed by insurance, including coinsurance and copayments. Paying for premiums is fairly straightforward because it is a set fee per member per month. Out-of-pocket costs may be harder to track, verify, and pay through a manual process because of the variety of permissible copays and coinsurance for which the state would assume payment responsibility, while tracking deductible and out-of-pocket maximums.

DCBS has identified possibilities to address these and other challenges, as described in the recommendations below, but DCBS would not know the best solution until it actually began the process of building the program and testing various solutions. If the specific requirements of the program were set by law, DCBS might not have the flexibility it needs to make adjustments and improvements that increase cost-effectiveness and better serve program participants.

ii. Program eligibility requirements

Recommendation: In general, program eligibility requirements should align with other related federal and state program requirements, including requirements of HealthCare.gov.

Eligibility requirements include who is eligible for the program, how they can apply and enroll, and under what circumstances their eligibility would be terminated. In general, DCBS recommends that program eligibility requirements align with other related federal and state program requirements. This will help avoid creating additional burdens for participants or standards that contradict already established requirements for related programs, including Medicaid and marketplace coverage through HealthCare.gov.

DCBS recommends the following requirements for program eligibility, which would be set by administrative rule:

1. An Individual is eligible for enrollment in the COFA islander premium assistance program if he/she meets all of the following criteria:

    1.1. The individual is a resident of Oregon;

Anyone who applies for health insurance through HealthCare.gov must provide their state of residence as part of their application. Only Oregon residents can purchase health insurance through Oregon's marketplace so DCBS would not need to independently verify a participant's state of residence. HealthCare.gov also requires that enrollees provide notice whenever they move.

DCBS does not recommend setting a minimum time limit for state residency. The ACA restricts residency determination to being a legal resident of the United States, not of a particular state. DCBS, as noted above, would like to align program requirements with HealthCare.gov's requirements to avoid creating additional burdens for either the state in administering the program or participants in joining the program.

During advisory group discussions, the question was raised if a premium assistance program could possibly attract COFA islanders from elsewhere to Oregon. DCBS is not able to determine the likelihood of that scenario. However, the state of Hawaii is moving forward with a similar assistance program, and other states with significant COFA populations may also consider establishing such programs.

1.2. <u>The individual household's annual modified adjusted gross income is equal to or less than 133 percent of the federal poverty level (FPL) after application of the 5 percent disregard</u>;

HB 2522 did not define what "low-income" means. During several advisory group meetings, the advisory group and DCBS discussed what the income level cut-off would be for the program.

Some stakeholders noted that 200 percent and below of the federal poverty level was considered by many groups to be "low-income." Other stakeholders, however, noted that 133 percent[1] of the federal poverty level was the income level cut-off for Medicaid in Oregon. Providing low or no-cost coverage through the marketplace for COFA islanders at 133 percent or below would, in effect, allow those COFA islanders not eligible for Medicaid (as result of the Federal Personal Responsibility and Work Opportunities Act of 1996) to receive coverage roughly equivalent to Medicaid, helping create parity between low-income COFA islanders and other similarly low-income Oregonians. If the program covered COFA islanders above 133 percent of the federal poverty level, the program would create a benefit for COFA islanders that other Oregonians with similar incomes would not receive.

At the request of members of the advisory group, DCBS compared the potential cost of covering premiums for COFA islanders at or below 133 percent of the federal poverty level with

[1] Medicaid disregards 5 percent of the applicant's income when determining eligibility, so in effect, the cut-off is actually 138 percent. When 133 percent is used in this report, it means 133 percent with the 5 percent disregard.

the cost of covering those at or below 200 percent of the federal poverty level as detailed in the chart below[2]:

Estimated annual cost to the state to cover **just** premiums for COFA islanders at or below 133 percent of the federal poverty level	$318,000 - $477,000
Estimated annual cost to the state to cover premiums **and** in-network out-of-pocket costs for COFA islanders at or below 133 percent of the federal poverty level	$818,000 - $1,602,000
Estimated annual cost to the state to cover **just** premiums for COFA islanders at or below 200 percent of the federal poverty level	$1,393,000 -1,590,000

The Legislative Assembly could choose to make funding available to cover the premium costs for COFA islanders at or below 200 percent of the federal poverty level. However, it would require a significantly larger amount of funding than to cover the premium costs for those at 133 percent and below. In fact, it would probably cost the state less to cover both premiums **and** in-network out-of-pocket costs for COFA islanders at or below 133 percent than to cover just premiums for 200 percent and below.

Based on the potential costs of the program and to establish premium assistance for COFA adults who would otherwise be eligible for Medicaid if not for their immigration status, DCBS recommends setting the income eligibility limit at 133 percent of the federal poverty level and below. HB 2522 states that the program should cover both premiums and out-of-pocket costs, which is more financially feasible for the state to do if it sets the limit at 133 percent and below. Covering out-of-pocket costs in addition to premiums would also allow qualifying COFA islanders to receive essentially no-cost, in-network coverage that would be comparable to Medicaid coverage.

1.3. The individual is not eligible for the Oregon Health Plan ("Medicaid");

While most COFA adults are not eligible for Medicaid as a result of the Federal Personal Responsibility and Work Opportunities Act of 1996, COFA children and certain COFA adults, such as those who are pregnant, may be eligible for Medicaid. Individuals eligible for Medicaid would not be eligible for the premium assistance program. Individuals are not allowed by federal law to be enrolled in Medicaid and a qualified health plan through the marketplace at the same time.

1.4. The individual is able to provide HealthCare.gov proof of his/her COFA citizenship for eligibility determination (https://www.healthcare.gov/immigrants/immigration-status/);

[2] See the cost of the program section below for an explanation of how DCBS developed its cost estimates. Ranges are for estimated 1,000 to 1,500 persons below 133 percent FPL. The estimate for the total below 200 percent FPL includes a range of income distribution for an additional 1,000 COFA persons for a total of 2,500 COFA persons. All costs estimates assume one-person households. Cost estimates in this table just include assistance costs and do not include estimated administration costs for DCBS.

HealthCare.gov requires certain documentation to determine eligibility for marketplace coverage.

Stakeholders have noted that some COFA islanders may not have easy access to proof of citizenship documents. DCBS proposes to work with stakeholders to help educate potential participants about what documentation is required and how to obtain it. Stakeholders have also offered to work with COFA island consulates to obtain any documentation participants may need.

1.5. The individual is able to provide his/her HealthCare.gov proof of enrollment in a qualified cost-share reduction silver- level health plan that corresponds to a household income equal to or less than 133 percent FPL to DCBS; and

To enroll in a qualified, cost-share reduction, silver-level plan through HealthCare.gov, consumers need to meet certain requirements, including but not limited to income and immigration status requirements. Requiring proof of enrollment allows the state to verify that participants met those requirements. In addition, proof of enrollment in a cost-share reduction variant of a silver-level plan helps to ensure that participants receive all available federal subsidies to help pay for coverage (see the section below about the cost of the program for more information about federal subsidies).

1.6. The individual is able to send to the Oregon marketplace the original invoice or bill from his/her health insurance carrier for monthly settlement of premiums.

Once a customer enrolls in health insurance through HealthCare.gov, HealthCare.gov notifies the insurer, and the insurer then sends a bill to the customer. The process is automated between HealthCare.gov and insurers' systems. Since the process is outside DCBS's control, it is unlikely that changes could be made to automatically identify premium assistance program participants and have their bills directed to DCBS. DCBS would most likely need program participants to submit their bills to DCBS, and then DCBS would settle the bills with insurers. In addition, by continuing to provide DCBS with their bills, program participants are notifying DCBS of their desire and eligibility to continue to participate. The requirement to forward bills to DCBS should also remind participants to report required changes, such as change of address.

2. A recipient's eligibility for the premium assistance program shall be terminated for any of the following reasons:

As with eligibility criteria, DCBS aligned termination criteria with the requirements of other related state and federal programs, including the requirements of HealthCare.gov and Hawaii's COFA premium assistance program.

During advisory group discussions, a stakeholder asked if eligibility could be effective for 12 months, meaning that once DCBS finds an individual eligible, they would continue to be eligible

for the next 12 months, regardless of life changes and other factors. HealthCare.gov requires the reporting of life changes and will modify or terminate coverage in certain circumstances. For example, if a person's income changes, the amount of subsidies they qualify for changes as well. DCBS proposes a comprehensive outreach and education campaign to help ensure that participants understand the importance of reporting life changes as required.

Below are the circumstances under which DCBS would terminate assistance.

2.1. The recipient no longer meets one or more of the program eligibility criteria;

2.2. Death of the recipient;

2.3. The recipient no longer resides in Oregon;

2.4. The recipient voluntarily terminates coverage;

2.5. The recipient is incarcerated post-conviction;

2.6. The recipient does not report life and income changes as required by HealthCare.gov (https://www.healthcare.gov/reporting-changes/which-changes-to-report/);

2.7. The recipient performs an act, practice, or omission that constitutes fraud, and the insurance plan is rescinded as a result;

2.8. Lack of state funds; or

2.9. The program is terminated or repealed.

iii. The amount of assistance

Recommendation: If enough funding is made available, the premium assistance program should cover the individual's share of premium and in-network out-of-pocket costs to create coverage roughly equivalent to Medicaid. By limiting plan selection to cost-share reduction variants of silver-level plans, the state can maximize federal subsidies, limit out-of-pocket expenses for the state, and provide participants with benefits more generous than a platinum plan.

HB 2522 states that premium assistance includes "the payment or reimbursement of premium costs for a qualified health plan and the out-of-pocket costs associated with receiving services covered by the plan." Premium costs are the fixed monthly costs consumers must pay for their health insurance.

Depending on the amount of funding made available, DCBS could provide assistance for:

- A portion of the individual's share of premium costs;
- The entirety of the individual's share of premium costs;
- The entirety of the individual's share of premium costs and a portion of the individual's share of in-network out-of-pocket costs; or
- The entirety of the individual's share of both premium and in-network out-of-pocket costs.

DCBS recommends leveraging federal subsidies and, if enough state funding is made available, covering the entirety of the individual's share of premium and in-network out-of-pocket costs to create coverage roughly equivalent to Medicaid. If there is not enough funding to cover the entirety of premiums and in-network out-of-pocket costs, DCBS could develop a process for capping expenditures for all participants to avoid exceeding available funding, though this may not be the best approach.

Premiums:
Many consumers who purchase health insurance through the marketplace are only required to contribute a set percentage of their income toward premiums. The federal government provides subsidies, called advanced premium tax credits (APTC), to help pay for the remainder. The amount of APTC an individual qualifies for is the difference between the premium cost of the second-lowest-cost silver plan in the individual's area and the capped amount the individual is required to pay.

For example, an individual at 133 percent of the federal poverty level would make $15,654 per year in 2016. That individual is required to pay only 2.03 percent of their income toward their premiums, which is about $318 for the year. In Multnomah County, the premium cost of the second lowest cost silver plan is $261 per month or $3,132 per year. In this case, the individual would qualify for $2,814 in APTC ($3,132 - $318 = $2,814) for the 2016 coverage year.

If the state covers the capped amount the individual is required to pay toward premium costs, the rest of the premium cost would be covered by the federal government. The individual would not need to pay any premium costs on their own. As can be seen in the cost of the program section below, DCBS estimates that for around $477,000, the state could cover the portion of premiums for which program participants are responsible.

The state could also contribute just a portion of the individual's share of premiums to reduce costs for the state. In such a case, DCBS would most likely divide available funding in equal amounts among participants. However, requiring low-income individuals to pay a portion of the premium could be a barrier to participation in the program. The program also would no longer create coverage comparable to Medicaid, since Medicaid does not require any premium payments.

Out-of-pocket Costs:

Low-income consumers who purchase health insurance through the marketplace can qualify for cost-share reductions if they select a silver-level plan. Cost-share reductions are federal subsidies that reduce out-of-pocket costs for customers. The total amount a customer must contribute each year toward essential health benefits is capped, and the cap is referred to as the out-of-pocket maximum. Different plans have different out-of-pocket maximums.

The state could limit out-of-pocket costs by limiting program participants to cost-share reduction (CSR) variants of silver-level plans. At this low income level, these plans have a 94 percent actuarial value, which is more generous than a platinum plan. DCBS estimates assume that the state's obligation would be limited to covering the maximum annual out-of-pocket costs for in-network essential health benefits, typically $500-750 for an individual. That would allow the state to maximize the federal subsidies available, set a cap on the state's contribution, and provide coverage roughly equivalent to Medicaid for participants. The estimated maximum cost to the state for covering in-network out-of-pocket costs in this scenario would be around $1,125,000 per year.[3] If funding is available, DCBS recommends this approach because it maximizes federal funds, limits state contribution, and provides generous coverage, without exposing the state to potentially much larger expenses for out-of-network services[4].

The state could also cover a portion of out-of-pocket costs. Allocating funding equitably among participants could be problematic and potentially hard to administer due to the uncertainty regarding when out-of-pocket costs would be incurred, how much they would be, and how the payment process would work. Also, as noted above under the premiums section, requiring low-income individuals to pay a portion of the out-of-pocket costs could be a barrier to participation in the program. Additionally, the program would no longer be as comparable to Medicaid.

iv. How the assistance should be distributed among eligible individuals

Recommendation: DCBS should pay insurance companies directly for participants' premiums and should look for ways to streamline the payment of in-network out-of-pocket costs to avoid administrative burden for the state and barriers for participants. When determining program specifics, such as plan selection, DCBS will need to find a way to balance the interests of the state, insurers, and program participants.

As noted above, changes cannot be made to HealthCare.gov so COFA islanders cannot apply for the premium assistance program or receive state assistance through the federal website. DCBS could possibly work with insurers to bill DCBS directly for participant costs. However, that would most likely require changes to insurer systems and processes, and DCBS does not have enough information to verify the costs of these changes or how viable this option is.

[3] This estimate assumes 1,500 participants and that every person will reach the out-of-pocket maximum for a sample plan with a $750 out-of-pocket maximum.

[4] For example, one 94 percent actuarial value CSR variant silver plan in 2016 has $600 maximum out-of-pocket for a person using in-network providers and $13,700 a person using non-network providers.

DCBS would most likely need to develop a manual process for administering the program and distributing assistance. Setting up payments for premiums would be fairly straightforward; participants would send their bills to DCBS, and DCBS would pay the insurer. Payment of in-network out-of-pocket costs, however, presents a challenge for DCBS for the reasons mentioned earlier in this report.

During advisory group meetings, DCBS and stakeholders discussed two possible options for distributing assistance for out-of-pocket expenses:

1) Participants could pay for in-network out-of-pocket expenses and then seek reimbursement from DCBS. Participants would need to submit proof of payment to DCBS, and DCBS would then issue them a check. This sort of manual reimbursement process for the estimated 1,000 to 1,500 participants could become administratively burdensome for DCBS. Participants might also have difficulty paying in-network out-of-pocket expenses up front, which could discourage them from getting the care they need.

2) DCBS could try to set up a system that made funds available for in-network out-of-pocket expenses at the time they are incurred. An example might be a health benefits payment card that could only be used at approved vendors. Participants could use the card to pay at the time of service, and DCBS would then monitor expenses to ensure their eligibility for reimbursement. With this option, participants would not have to cover in-network out-of-pocket expenses up front themselves, making it easier for them to get the care they need. DCBS has done some research into this option but needs to explore it in more depth to determine its viability.

DCBS will need to work with stakeholders further to determine the best option for distributing assistance. Any process that DCBS develops would require balancing the interests of the state, insurers, and program participants. This includes determining what plans participants could select. As noted above, DCBS recommends limiting plan selection to cost-share reduction silver-level plans to maximize federal subsidies. If plan selection is limited to certain cost-share reduction silver plans, DCBS would need to work with insurers and stakeholders to determine the number of plans to offer to ensure meaningful choice for participants, fairness to insurers, and administrative streamlining for the state.

A manual process could work as follows:

- COFA islanders would submit an application to DCBS to participate in the program.
- DCBS would review the application and provide instructions on next steps.
- COFA islanders would then:
    - Enroll in a 94 percent actuarial value silver-level plan through HealthCare.gov,
    - Provide proof of enrollment to DCBS, and
    - Forward their health insurance premium bills to DCBS for payment.
- DCBS would then pay insurers directly for the premiums.

- DCBS would design a process with program participants for paying or reimbursing in-network out-of-pocket costs.
- Participants would need to report life changes to HealthCare.gov and to DCBS and reapply to the program and for health insurance each year.

v. The cost and financing of the program, including whether federal funds or other funds may be available.

Recommendation: The premium assistance program should leverage federal subsidies for participants. State funding will be necessary to provide assistance to pay for the individual's share of premiums and in-network out-of-pocket costs, and DCBS will need additional resources in order to administer the program.

DCBS estimates that the maximum total cost of the program for the state would be between $1,039,000 and $1,823,000 per year, assuming 1,000 to 1,500 participants in the program. This includes between $818,000 to $1,602,000 per year for assistance and $221,000 per year for administration.

As noted above under the section about the amount of assistance, the federal government provides significant subsidies for low-income consumers. Participants in the program could potentially receive $2,814,000 to $4,221,000 in federal premium tax credit subsidies paid to the insurers on their behalf, in addition to what the state would provide.

If the program is limited to those COFA islanders with income at or below 133 percent of the federal poverty level and silver-level plans, all program participants would also qualify for the highest level of cost-share reductions, the 94 percent actuarial value plan.

Cost of Assistance

DCBS has created projections for the cost of covering premiums and in-network out-of-pocket expenses for program participants. These projections include estimates of the advanced premium tax credits (APTC) provided by the federal government. Please see Attachment A for a more detailed version of these tables.

The projections assume a total possible eligible population of 1,000 to 1,500 COFA islanders. OHA provided this estimate, which accounted for COFA children and pregnant women enrolled in the Children's Health Insurance Program (CHIP) and Medicaid, as well as, an estimated number of those in households above 133 percent of the federal poverty level and an estimated number of those who had employment-based coverage.

In the chart below, DCBS estimates that the maximum annual cost of covering premiums for 1,000 to 1,500 COFA islanders would be about $318,000 to $477,000 for those at 133 percent

or below of the federal poverty level.[5] This assumes that every single participant has a household size of "one," the most expensive coverage option. It also assumes that all potentially eligible individuals sign up immediately and continue coverage for the whole year. Please note that the amount of APTC is just an example (for a 40-year-old non-smoker in Clackamas, Multnomah, or Washington County, in this case). The actual amount of APTC will vary depending on the location of the individual. The "max premium per year" is the capped amount an individual at 133 percent of the federal poverty level has to pay toward his/her premiums. That capped amount is what the state would cover for each participant.

As can be seen in the table below, the federal contribution toward premiums is approximately $9 for every $1 the state would contribute toward premiums. The exact ratio of federal dollars to state contribution would depend on how many people participate from what counties, as the APTC will vary based on the second-lowest-cost silver plan. But, in all instances, the federal-to-state premium contribution ratio for one-person households would be at least nine-to-one.

Household Size	Annual Income	Max Premium per Year	Estimated APTC per Year	Estimated Annual Premium Cost Payable by the State		Estimated APTC Contribution by Federal Government	
				1,000 Persons	1,500 Persons	1,000 Persons	1,500 Persons
1	$15,654	$318	$2,814	$318,000	$477,000	$2,814,000	$4,221,000

In the next table, DCBS estimates that the maximum cost of covering premiums and in-network out-of pocket costs for 1,000 to 1,500 COFA islanders would be about $1,068,000 to $1,602,000 for those at 133 percent or below of the federal poverty level. Like the table above, this assumes a one-person household for each participant. The types of plans listed are just examples. The out-of-pocket maximum differs per plan, but these amounts are typical for cost-share reduction variations of silver-level plans with 94 percent actuarial value. Please note that this estimate of maximum expense for the state assumes all enrollees reach 100 percent of their in-network out-of-pocket maximum and remain covered for 12 months.

Plan Type	Individual Obligation		Estimated Premium and Out-of-pocket Cost Payable by the State
	Maximum	Maximum	

[5] These calculations are based on 2016 figures for household income, percentage required contribution from member toward premium, and second lowest cost silver plan in Clackamas, Multnomah and Washington counties. Projections for 2017 anticipate slight increases in member/premium assistance program obligations to about $326,000 to $489,000 to serve 1,000 to 1,500 persons below 133 percent of the federal poverty level for the full calendar year.

	Premium per Year	Out-of-pocket per Year[6]	Per Person	1,000 Persons	1,500 Persons
Plans with lower copays, coinsurance and deductibles and reduced maximum out-of-pocket	$318	$750	$1,068	$1,068,000	$1,602,000
Plans with same copays, coinsurance and deductibles as a regular silver plan, but reduced maximum out-of-pocket	$318	$500	$818	$818,000	$1,227,000

Cost of Administration

DCBS will look for ways to streamline processes and the administration of the program, but most processes will have to be manual. Manual processes tend to be more labor-intensive than automated processes.

Currently, DCBS does not have the staff necessary to handle the additional work involved in administering the program. DCBS estimates that it will need to hire one additional full-time employee (FTE) to manage the program, including:

- Developing program processes and policies;
- Enrolling participants;
- Coordinating with insurers; and
- Making and tracking payments to insurers and participants.

In addition, DCBS anticipates a need for outreach about the program. DCBS will need to educate COFA islanders about the program and provide them with instruction on how to participate in the program. Many participants may be unfamiliar with health insurance through HealthCare.gov so DCBS also anticipates the need for general education about how to enroll in insurance and use it to access health care. DCBS will work with stakeholders on all outreach efforts to maximize existing communication networks.

[6] The federal government reimburses carriers for the difference between the maximum out-of-pocket for a silver-level plan and the costs the carrier incurs for the cost-sharing reduction version of the silver plan. This is done through ongoing advances from the federal government and a year-end reconciliation calculation to determine the amount owed to the carrier for its members enrolled in cost-share reduction plans.

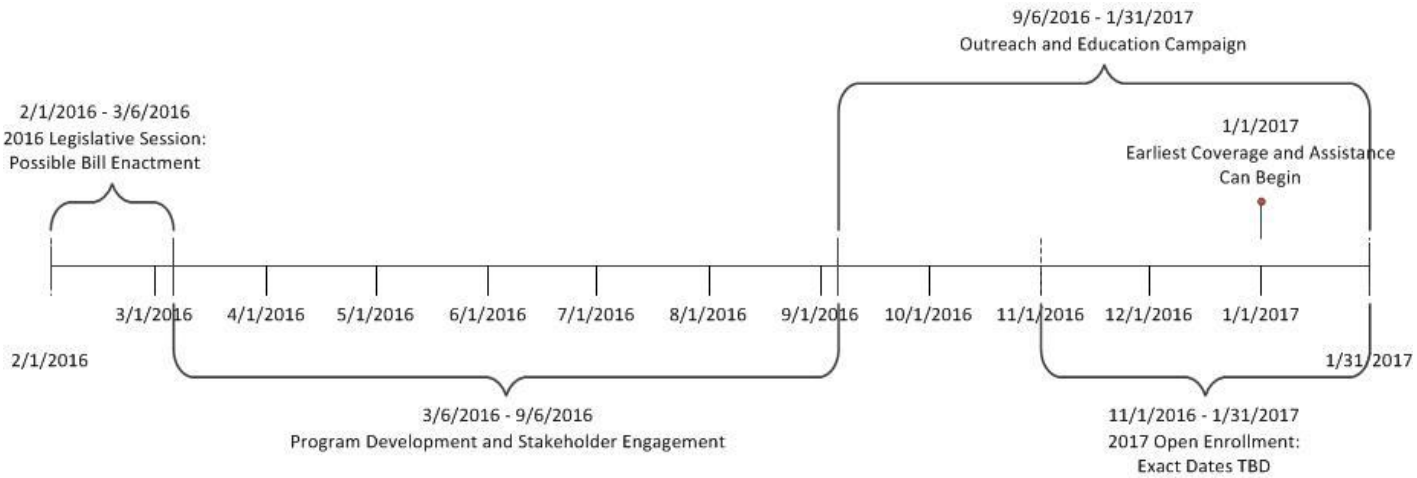
As shown in the chart below, DCBS estimates that the total cost of program administration would be about $221,000 per year.

ADMINISTRATION		
Human resources	$88,000	
Service and supplies	$76,000	**$164,000**
OUTREACH		
English brochure and handout in two other languages	$13,000	
Webpage and online form development	$7,000	
Community events	$7,000	
Community partner support	$3,000	
COFA community group support	$13,000	
Other materials	$5,000	
Paid media	$9,000	**$57,000**
TOTAL		**$221,000**

Note: Projections do not include any expenses to implement a payment card mechanism, as contemplated in the section above about how to distribute assistance. If the Legislative Assembly passes a bill to implement the program, DCBS will complete a Request for Proposal process to determine actual costs for payment card mechanism.

vi. Program implementation

Recommendation: DCBS will need at least six months to develop the program. Initial enrollment in the program should coincide with the 2017 plan year open enrollment period (fall 2016).



DCBS estimates that it would need at least six months to develop the program after enactment of a law that authorizes and funds it. During that six-month period, DCBS would do the following:

- Perform additional research, including research into possible payment mechanisms;
- Continue meeting with stakeholders and community members for input and feedback;
- Work with CMS to ensure compliance with federal rules and regulations;
- Create administrative rules with input and feedback from an advisory group;
- Determine program policies and procedures;
- Recruit, hire, and train the staff needed to handle the work;
- Work with insurers and stakeholders on plan selection;
- Develop outreach and education plans and materials; and
- Prepare for program implementation.

Once DCBS develops the program, it would begin performing outreach and education in the community with the support of stakeholders in order to inform potential participants about the program and prepare them to enroll, which would help maximize participation in the program from the start.

In order to enroll in the program, participants would need to enroll in health insurance through HealthCare.gov. HealthCare.gov allows consumers to enroll during the annual open enrollment period, which usually begins in the fall and ends mid-winter (for example, open enrollment for the 2016 plan year is November 1, 2015 through January 31, 2016). HealthCare.gov also allows special enrollment periods, times outside of the open enrollment period when consumers with certain circumstances can sign up.

For the first year, enrollment in the program should start when open enrollment begins for the 2017 plan year (fall 2016). Assistance from the state for the cost of premiums and in-network out-of-pocket expenses would begin once insurance coverage begins.

Enrollment in the program could start sooner if the State of Oregon requests a special enrollment period for program participants from HealthCare.gov and CMS grants the request. In order to obtain a special enrollment period for the program, DCBS would have to work with CMS to set up the special enrollment period, and DCBS will need to do more research in order to determine how long the process would take and what it would involve. However, given the timing, it is likely that program participants would be required to enroll during a special enrollment and within weeks, would have to re-enroll during open enrollment. For this reason, DCBS recommends that the initial and subsequent enrollment coincide with open enrollment.

vii. Coordination with other affordability efforts

DCBS should coordinate the development of this program with other affordability efforts underway; however, the proposed program will most likely help COFA islanders access affordable, high quality health insurance sooner than other efforts.

DCBS acknowledges that there are other efforts underway at the state and federal level that may address the health insurance needs of COFA islanders, such as a possible Basic Health Plan

(BHP) in Oregon. However, DCBS recommends implementation of the proposed premium assistance program because it can begin to address the health insurance needs of COFA sooner than other efforts.

ATTACHMENT A

PREMIUM ASSISTANCE ONLY
EXTENDED UP TO 200 PERCENT FPL

	COFA – ONLY	ALL OREGON RESIDENTS 138-200 PERCENT FPL
2016 Estimated Premium Cost Payable by the State	$1,590,000	$81,469,000
2016-2017 Biennial Estimated Premium Cost Payable by the State	$3,181,000	$162,938,000

Assumptions in this estimate include:

1. Population estimates:
   - COFA 1,000 persons added in the 138-200 percent FPL households to 1,500 below 138 percent FPL, for a total of 2,500 persons under 200 percent FPL. For this estimate DCBS assumed half of the COFA persons in households at 150 percent FPL and half were in 200 percent FPL households. DCBS does not have access to reliable data that breaks the COFA population into finer increments than 138-200 percent FPL. This rough estimate is based on reported total population. If DCBS assumed that only one-quarter of the additional persons above 138 percent FPL were in 200 percent FPL households, that would reduce the COFA estimates to $1,393,000 annually and $2,786,000 for a biennium.
   - 88,600 QHP eligible Oregonians in 138-200 percent FPL households. Source: a study commissioned by HHS for marketplaces, with detailed analysis of census bureau and other data. DCBS does not have access to reliable data that breaks this total population into finer increments than 138-150 percent FPL and more than 150-200 percent FPL. For the purpose of this example, DCBS made the same assumptions as with the COFA households: half were at 150 percent FPL and half were at 200 percent FPL.

2. Those that increase the cost estimate:
   - Full annual uptake.
   - All households are 1-person households (COFA or any Oregon resident).

3. Those that decrease the cost estimate:
   - The percentage of household income required to be paid/premium cap would not increase in 2017. In reality, it will by a very small amount, but like all estimates included in this report, the percentages of household income are the known figures for 2016.

Individual Share of Premium			
1-Person Household (2016)	**Household Income**	**Percentage of Income Individual Required to Pay**	**Premium Cap**
133 percent FPL	$15,654	0.0203	$ 318
150 percent FPL	$17,655	0.0407	$ 719
200 percent FPL	$23,540	0.0641	$1,509

COMPARING TWO PLAN OPTIONS THAT HAVE
COST-SHARING REDUCTION (CSR) 94 PERCENT ACTUARIAL VALUE:

There would generally be more transactions required in Plan A than in Plan B to reach the maximum in-network out-of-pocket at which point the insurer would cover 100 percent of covered health care costs.

Plan Name	Max Out-of-Pocket In Network	Generic Drugs	Brand Name Drugs	Non-preferred Brand Drugs	Primary Care Visit	Specialist Visit	In-Patient Hospital
Plan A	$750/person $1,500/family	$5 copay	$10 copay	25 percent coinsurance	$10 copay	$20 copay	10 percent coinsurance
Plan B	$500/person $1,000/family	$15 copay	$50 copay	50 percent coinsurance	$35 copay	$70 copay	30 percent coinsurance